General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dispensary Green, Unit 3, Sherwood Network Centre, Newton Hill, New Ollerton, Nottinghamshire, NG22 9FD

Pharmacy reference: 9011755

Type of pharmacy: Internet

Date of inspection: 19/06/2023

Pharmacy context

This is an internet pharmacy with physical access to the premises closed to the public. It provides both NHS and private services. The pharmacy specialises in dispensing private prescriptions for specific controlled drugs received directly from Care Quality Commission (CQC) registered clinics. And people can nominate the pharmacy to receive and dispense their NHS prescriptions. Through its NHS service the pharmacy dispenses some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it supplies medicines to people living in care homes. It supplies the medicines it dispenses through a delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has relevant written procedures which help team members manage risk and provide services safely. It keeps the records required by law in good order and it has effective processes for managing and responding to feedback from people using its services. It holds people's personal information securely and its team members understand their role in helping to safeguard vulnerable people. They regularly share learning by discussing the mistakes they make during the dispensing process. And they act to reduce risk following these discussions. The pharmacy monitors its services through interventions, and it completes some audits. But this does not extend to the completion of regular clinical audits. So, the pharmacy may miss out on opportunities to improve its services.

Inspector's evidence

The pharmacy was part of a wider group providing specialist services associated with the prescribing and supply of specific controlled drugs (CDs), many of which were unlicensed medicines, also known as 'specials.' It operated as a separate legal entity to the prescribing service. And it offered its secure digital platform to the group's own clinic and to other CQC registered clinics prescribing these specific CDs. Around 80% of its workload was generated from the group's own CQC registered clinic, based in London. The pharmacy's digital platform allowed clinics to securely upload scans of private prescriptions for the specific CDs ahead of providing the pharmacy with a hard copy of the prescription. Each clinic was registered separately on the platform, as was each prescriber. All prescriptions dispensed through the private service were on NHS CD private prescription forms. The pharmacy employed a dedicated team of patient coordinators who worked remotely from the pharmacy. This team worked in a customer service facing role, managing registration, taking payments, and answering non-clinical queries from people accessing the service. Patient coordinators could contact a member of the in-house pharmacy administration or dispensing team live when speaking to a person to support them in answering queries.

The pharmacy had an internal risk assessment for the conditions and specific CDs it supplied. The risk assessment contained details of identified risks and controls to minimise these risks. It had been introduced in February 2023 and had a review date of January 2024. The pharmacy also had an operational risk assessment. This focussed on areas such as health and safety, business contingency, training, confidentiality and the supply and delivery of medicines. There was evidence of version control and updates in relation to this risk assessment. The pharmacy minimised some risks by clearly separating tasks associated with the two sides of its business model by having two dispensaries: one for the private services and the other for NHS services. Each dispensary had a set of standard operating procedures (SOPs). These were reviewed two yearly and there was a SOP review and change request form available for team members to complete, if they found any inconsistencies between the documented SOP and what happened in practice. There was a range of helpful appendices to the SOPs to support pharmacy team members in their role. A sample of training records confirmed team members had completed training competencies in relation to the SOPs and had signed to accept they would work in accordance with them. All team members on duty were confident in demonstrating how they completed their tasks and showed a clear understanding of both their own job roles, and of the job roles of other team members. Newer team members were supported initially during their induction process by shadowing colleagues before undertaking tasks themselves. Pharmacy team members were knowledgeable about the types of medicines they handled and understood processes required by law.

For example, the requirement to have the original prescription onsite before supplying a CD. Workload was managed well with planned time in each dispensary for the pharmacist to complete clinical checks of prescriptions and accuracy checks of medicines.

The pharmacy had completed an audit associated with the supply of medicines through its delivery service in 2022 and a more recent audit associated with its compliance with dispensing valproate according to the Pregnancy Prevention Programme (PPP). But it had not completed any specific clinical audits related to the supply of medicines through its private service. Information provided shortly after the inspection included intervention records associated with identification of potential excessive supplies and identification checks. This supported the ongoing monitoring of the pharmacy's risk management processes. But the documents did not monitor day-to-day performance of the pharmacy's services against a known standard, a key requirement in a clinical audit. The pharmacy submitted the private CD prescriptions to the NHS Business Services Authority every month as required, so there was external visibility of prescribing activity. But any prescribing data generated through following this process would not be shared with the pharmacy.

The pharmacy had tools to support its team members in recording mistakes found and corrected during the dispensing process, known as near misses. There was evidence of consistent near miss recording across both dispensaries. And team members were knowledgeable about the actions taken to reduce risk. This included improving learning associated with the specific products stocked and ensuring those with similar names and packaging were not held close together. Pharmacy team members understood how to respond to, and report mistakes identified following a person receiving their medicine, known as dispensing incidents. And the pharmacy kept electronic reports associated with these types of mistakes. This included details of the investigation and actions taken to reduce a similar incident occurring. For example, it had introduced a system of numbering individual items on prescription forms to help ensure no items were missed. And it routinely recorded the batch number and expiry date of each item dispensed on prescription forms to support it in responding to a query. Pharmacy team members engaged in regular team meetings to share learning from patient safety events and the team documented these learning points.

The pharmacy had a procedure for managing feedback and complaints. And it provided clear information on its website about how people could contact the pharmacy or raise a concern. The pharmacy's patient coordinators liaised with the onsite pharmacy team and clinics when resolving these concerns. Concerns were escalated to the pharmacy manager and the SI. All calls were recorded and assigned a ticket number to help track the status of the query or concern. The team demonstrated how a trend in feedback about the delivery service associated with the private service had led to the pharmacy changing the courier it used. The pharmacy had specific SOPs relating to safeguarding vulnerable people. And contact information for safeguarding teams was accessible. Pharmacy team members described how they would identify, and report safeguarding concerns and they had completed some learning on the subject. The pharmacy completed identification checks when people registered to use its services to ensure it was supplying medicines to the correct person.

The pharmacy had current indemnity insurance arrangements. A sample of records required by law were examined. The responsible pharmacist (RP) notice was displayed prominently and contained the correct details of the RP on duty. The RP record was held electronically and completed as required. The pharmacy held completed certificates of conformity for the specials medicines it dispensed in individual trays correlating to each of the special's manufacturers it used. It sent these to a centralised secure storage facility every few months to help manage the amount of documentation it held onsite. Team members confirmed that these could be retrieved if needed. The pharmacy kept an up-to-date electronic CD register with daily balance checks of physical stock against the register by two people. Physical balances of two CDs checked during the inspection complied with the balances recorded in the

register. Entries within the register were seen to comply with legal requirements. Batch numbers and expiry dates of specific CDs were recorded in the register to assist with queries. The pharmacy had specific procedures relating to information governance and data security. These set out clearly how it protected people's confidentiality. Its website contained details of its privacy policy and its staff handbook reinforced how its team members should process people's confidential information. All records were held securely and there was no public access to the building. The pharmacy held confidential waste securely and this was collected periodically by a secure shredding company.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a suitable team of people to manage its workload. And it encourages its team members to feedback their ideas and share learning through regular communication. Pharmacy team members engage in ongoing learning relevant to their role. They work together well, and they feel comfortable raising concerns and know how to escalate concerns if necessary.

Inspector's evidence

The onsite pharmacy team consisted of the regular pharmacist, a pharmacy manager who was a qualified dispenser, six qualified dispensers, five administration assistants and a delivery driver. Two members of the administration team held dispenser qualifications and as such could support the dispensing team if required. The pharmacy also employed a team of patient coordinators who worked remotely. The pharmacy team was preparing to welcome a new superintendent pharmacist who commenced their role several days after the inspection. The full-time regular pharmacist had taken on this position in an interim role whilst the company had followed a recruitment process to appoint the permanent superintendent pharmacist. And confirmed they had felt supported working in this role during this interim period.

The regular pharmacist worked at the pharmacy four days a week. The remaining day each week was covered by locums who were provided with an induction pack and required to watch a training video about the specialist products dispensed. The RP had attended a one-day training course to support them in their role. And they had completed some specific e-learning provided by NHS Health Education England. These training activities didn't include assessments or activities to ascertain their level of understanding about the specific CDs handled by the pharmacy. The RP provided some examples of where they would question the appropriateness of a prescription, but this was restricted to formulation or dosages rather than suitability to prescribe. The pharmacy kept evidence of the learning its team members completed. This included accredited training as well as regular e-learning from a national training provider to support team members working within their roles. The pharmacy had an established induction learning pathway with specific learning associated with the bespoke nature of the pharmacy's business. Pharmacy team members received protected training time and regular appraisals within work to support their learning needs. In addition to personal learning there was evidence of regular team meetings taking place. The pharmacy kept notes of the topics and outcomes discussed within these meetings. And it displayed the most recent meeting's notes for its team members to read. The team meetings were well structured with topics including health and safety, processes, patient safety and learning discussed. Recent notes identified the need for team members to reduce noise levels in the dispensary when dispensing activities were taking place.

Pharmacy team members were not given any specific targets to meet. The RP felt able to apply their professional judgement when providing the pharmacy's services. The pharmacy had a whistleblowing policy. And its team members had a good understanding of how to raise concerns and share their feedback at work. They were confident in sharing their ideas and learning with each other. For example, a team member demonstrated how they had shared a learning fact sheet about the names of specific CDs with other members of the team. And the pharmacy had taken onboard another team member's idea to apply formal information notes to prescription forms to communicate key messages throughout the dispensing process.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for the provision of healthcare services. They are clean, secure, and well maintained. The pharmacy's website provides clear information to people about its services and registration status.

Inspector's evidence

The pharmacy was modern, secure and in a good state of repair. Visitors to the pharmacy were required to ring a bell for access and they signed into a visitor book and a confidentiality agreement. The pharmacy was clean throughout with floor spaces kept free from trip and fall hazards. Lighting was bright throughout the premises and portable air conditioning units were in use. Windows could also be opened during the working day to increase ventilation. The premises consisted of the reception area and administration office and two dispensaries. The dispensaries were an adequate size for the level of activity taking place. Team members also had access to kitchen and toilet facilities, including sinks equipped for hand washing.

The pharmacy's website included the name, address, and contact information for the pharmacy. The pharmacy used the GPhC's voluntary internet pharmacy logo, this linked directly to the GPhC's register. It also provided details of the SI. But it did not prominently advertise how to check the SI's registration status on its home page. The website provided a clear set of terms and conditions, a frequently asked questions section and the pharmacy's zero tolerance policy on harassment and abuse.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises it services clearly and makes them accessible for people. It only obtains medicines from licensed suppliers, and it stores its medicines safely and securely. The team completes regular checks to make sure medicines are in good condition and suitable to supply. And it has appropriate safeguards to help ensure people receive medicines that are clinically appropriate for them.

Inspector's evidence

The pharmacy's website provided people with information to help them access both its NHS and private services. The frequently asked questions section of the website provided specific information designed to support people understand timelines associated with receiving their medicine. And people using the private pharmacy service could track their prescriptions journey using the pharmacy's portal and personal log-in information. The website also provided health and lifestyle advice, including managing anxiety, fear, and panic. The pharmacy did not directly provide any consultation or prescribing services as these were provided by CQC registered clinics via face-to-face and remote consultations.

The pharmacy had established a formal onboarding procedure following its last inspection. It applied this before providing dispensing services for new clinics. The process included a formal interview, a request for professional documents such as indemnity insurance and proof of registry on the GMC specialists register and professional clinical scope of practice. The pharmacy's onboarding checklist also requested copies of the clinic's prescribing policies, risk assessment and audits. It also asked clinics for copies of shared care agreements if applicable, confirmation of contact with a person's GP, and continual professional development for its prescribers. The pharmacy team was proactive in their attempts of obtaining the complete set of information. But a number of clinics had outstanding information and the pharmacy didn't have clear deadlines regarding how long a clinic had to submit this information. Team members on duty were not aware of the pharmacy's minimum accepted information required for onboarding a clinic. And the pharmacy had dispensed some prescriptions for clinics which had not completed the full onboarding process. The pharmacy manager confirmed deadlines associated with the onboarding process had been set following the inspection.

The registration process for the digital platform required people to provide photographic identification. The offsite patient coordinator team managed this process. The administration team had sight of the registration process and was able to see that Identification checks had been completed before processing prescriptions. The administration team received notification of incoming prescriptions which included a scanned image of the prescription. This allowed them to complete a series of checks, including checking the prescription was legally valid and checks relating to the prescriber. For example, checking they were on the GMC's specialist register. They moved forward with processing the prescription by checking stock availability. Once the hard copy of the prescription was received by registered post the administration team completed the pre-dispensing checks and confirmed the availability of the medicine. A patient coordinator then sent a secure payment link to the person to pay for the prescription. The pharmacy kept a clear audit trail of each step of the prescription journey. This included recording details of who had processed the prescription at each stage. The pharmacy had a copy of prescribing policies for most of the clinics it worked with. And it was in the process of obtaining missing policies for remaining clinics. It submitted its private prescriptions for schedule two CDs to the

NHS Business Services Authority at the end of each month as required. Some prescriptions issued by clinics were post-dated and the pharmacy had appropriate processes to prevent the preparation and supply of medicines on these prescriptions before their due date. The pharmacy team understood the vulnerabilities in the supply chain of the specialist medicines it dispensed. It obtained regular stock status updates from its suppliers and shared this information with the clinics who sent prescriptions to the pharmacy. This attempted to avoid delays in people receiving their medicines.

The dispensing team completed labelling and assembly tasks prior to prescriptions being clinically and accuracy checked by the pharmacist. The team had applied learning following the last inspection to ensure the placement of labels on the medicines allowed people to read all the necessary safety and warning information on the packaging. The pharmacy supplied these medicines with specific information leaflets to support people in using them safely. The team packaged the medicines securely with a clear address label and tracking information. It held the packages securely until collected by the mail courier. The onsite pharmacy team escalated issues in the first instance to the patient coordinator team who liaised directly with the clinics. For example, if a person was prescribed two items but only wanted one of them dispensed. This situation prompted referral by the patient coordinator back to the prescriber to ensure this was clinically appropriate, and to allow the prescriber to update the person's care plan. The pharmacy had procedures to support the supply of medicines through its mail courier service. It had clear audit trails related to its delivery processes. The pharmacy supplied some medicines to people living in the Channel Islands. It had evidence of the import, and export licenses required for these supplies and people could track their delivery through the special dispatch numbers provided to them.

For the NHS service, members of the public nominated the pharmacy to receive their prescriptions. The pharmacy maintained an audit trail of the prescriptions it received and of the medicines it delivered. It dispensed medicines to people residing in care homes. And it had audit trails of the prescriptions it ordered and medicines it supplied for this service. It maintained a communication record to help manage its NHS services. This supported the team in responding to any queries it received. Team members took ownership of their work by signing the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. The pharmacy assembled some medicines in multi-compartment compliance packs for people residing both in care homes and in their own homes. It used individual records to support it in managing this service and in monitoring and recording changes to people's medicine regimens. A sample of assembled compliance packs contained full dispensing audit trails and clear information about the medicines assembled inside them. Patient information leaflets were seen to be provided. The pharmacy team had invested time in learning about the full requirements of the valproate PPP following the last inspection. And it retained evidence of key documents and a completed recent audit. The team had the tools to support the checks required if it received a prescription for a person within the at-risk group.

The pharmacy documented the checks it made to ensure it received medicines from licensed wholesalers and from licensed specials suppliers. But there was no review date on these documents to indicate how often the checks took place. Medicine storage was orderly throughout the pharmacy. The pharmacy held stock of CDs securely and storage within the secure cabinets was orderly. Due to the specific CDs being natural products they were vulnerable to environmental factors. The pharmacy engaged in temperature mapping audits to help ensure the storage environment inside the cabinets was appropriate. This involved fitting recording thermometers in each cabinet and analysing the data from these recordings. The pharmacy supplied the specific CDs within their original packaging. This reduced the risk of them being subject to any environmental factors within the pharmacy and during the transit process. The pharmacy stored medicines subject to cold chain requirements safely in a refrigerator. It kept a fridge temperature record to ensure it stored these medicines at the correct

temperature.

The team completed regular date checking tasks, and it marked short-dated medicines to ensure they remained safe to supply to people. Team members recorded opening dates on liquid medicines to help ensure they remained fit to supply. Pharmacy team members were aware of the short shelf-lives of many of the products they dispensed and actively checked expiry dates to ensure the medicine would remain in date for the duration of treatment. The pharmacy had appropriate medicine waste bins and CD denaturing kits to support in the safe disposal of pharmacy waste. It received details of medicine alerts by email. And it retained an audit trail of these alerts and any action it took in response to them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriately maintained equipment and facilities for providing its services. And its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date electronic reference resources. They could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computer systems were password protected and information was regularly backed up. The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. For example, calibrated measuring cylinders for measuring liquid medicines. Equipment associated with the supply of medicines in compliance packs was single use. Packaging materials used for the delivery of medicines was robust. Electrical equipment was in good working order and there was evidence of monitoring checks to ensure it was safe to use.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.